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### **Emerald Article: Efficiency or equity: value judgments in coverage decisions in Thailand**

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# Efficiency or equity: value judgments in coverage decisions in Thailand

Coverage  
decisions in  
Thailand

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## Abstract

**Purpose** – The purpose of this paper is to analyse the roles of social values in the reform of coverage decisions for Thailand's Universal Health Coverage (UC) plan in 2009 and 2010.

**Design/methodology/approach** – Qualitative techniques, including document review and personal communication, were employed for data collection and triangulation. All relevant data and information regarding the reform and three case study interventions were interpreted and analysed according to the thematic elements in the conceptual framework.

**Findings** – Social values determined changes in the UC plan in two steps: the development of coverage decision guidelines and the introduction of such guidelines in benefit package formulation. The former was guided by process values, while the latter was shaped by different content ideals of stakeholders and policymakers. Analysis of the three interventions suggests that in allocating its resources to subsidise particular services, the UC authority took into account not only cost-effectiveness, but also budget impacts, equity and solidarity. These social values competed with each other and, in many instances, the prioritisation of benefit candidates was not led solely by evidence, but also by value judgments, even though transparency was recognised as an ultimate goal of reform.

**Research limitations/implications** – The study findings indicate room for improvement and for future research – the current conceptual framework is inadequate to capture all the crucial elements which influence health prioritisation, as well as their interactions with social values.

**Originality/value** – The paper fills a gap in literature as it enhances understanding of the effects of social value judgments in real-life health prioritisation.

**Keywords** Thailand, Social values, Health care, Health organisation and management, Health priority setting, Coverage decisions, Value judgements

**Paper type** General review

## Introduction

Healthcare systems in developed and developing countries face common challenges in allocating the always limited available resources to meet the rising demand for essential services among needy populations. Prioritisation is, therefore, an inevitable

This article was developed as part of a collaborative effort to obtain insights into the construction of social values and their influence on health prioritisation. This project was initiated by the National Institute for Health and Clinical Excellence (NICE) and University College London, with support from the Wellcome and the Nuffield Trusts. The authors are grateful for useful comments from participants in the International Comparative Analysis Workshop on Social Values and Health Priority Setting, London, February 2011.



task of policymakers in public health authorities. A significant body of literature suggests that although evidence-based policy has long been promoted, decisions to invest in health technologies are complex, and not value-free (Sabik and Lie, 2008). Decision-making bodies in Sweden and Norway, for instance, take substantial account of human dignity, social solidarity or equity, and efficiency (Stafinski, 2010). In the UK, the National Institute for Health and Clinical Excellence has developed processes that allow participation in the making of decisions by patients and also accesses the views of lay people through the Citizens Council. These views have been consolidated into a set of social value judgments whose scope is much broader than only assessing cost-effectiveness. The institute's advisory committees are expected to take these fully into account when developing guidance (Littlejohns and Rawlins, 2010).

While a number of existing studies have discussed the implications of incorporating social values into health prioritisation, and others determine the relative importance of certain values in hypothetical scenarios in particular societies (Golan *et al.*, 2011; Youngkong *et al.*, 2010), none of these articles provide any comprehensive insight into the role of social values in real-life health resource allocation (Rawlins and Culyer, 2004; Shah *et al.*, 2010). This paper reviews experiences from a recent initiative in Thailand whereby different values competed with each other in determining the formulation of the benefit package of a publicly-subsidised plan – the Universal Health Coverage (UC) (Tangcharoensathien *et al.*, 2010).

Thailand's UC has been widely recognised as a successful model for tax-based health benefit schemes in the developing world (Hughes and Leethongdee, 2007). It was established in 2002 to complement two existing public health plans: the Medical Benefit Scheme for Government Workers and the Social Security Scheme for formal-sector private employees. The UC currently covers not only therapeutic and rehabilitating services for its beneficiaries, which account for 75 percent of Thailand's 67-million population, but also health promotion and disease prevention for all (National Health Security Office, 2007). The UC's benefits are decided by the National Health Security Office's (NHSO) Subcommittee for the Development of Benefit Package and Service Delivery (SCBP). Over the first nine years of UC implementation, the development of its benefit package was not governed by any explicit guidance. Selected technologies were mainly advocated by privileged groups, such as politicians, health professionals, activists, and the industry. This raised concerns among SCBP members as some essential interventions could be neglected, especially those intended for health promotion and disease prevention (HITAP-IHPP, 2011). Moreover, stakeholders who failed to exert any influence on the choice of UC benefits demanded a systematic and transparent approach. In response to this, a reform was introduced to enhance good governance of the coverage decisions.

As part of an international collaborative effort to encourage in-depth understandings of the impact of social values in health prioritisation, this study sheds light on Thailand's UC reform in 2009. It illustrates how new mechanisms for formulating the UC benefit package were devised in order to accommodate the previously mentioned values of stakeholders. Furthermore, this analysis assesses the roles of values in appraising candidate technologies during the first year of the reform initiative.

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### Methods and conceptual framework

Qualitative techniques were employed for the data collection and analysis in this study. Between March and June of 2010 extensive reviews were conducted of relevant documents, including the official website of the reform project ([www.hitap.net/bp](http://www.hitap.net/bp)), the minutes of the SCBP and related working groups' meetings, the records of stakeholder consultations, and research reports. Four out of the six authors had experience of participating in the reform under investigation, which allowed direct observations to be made regarding the development of the initiative and its determining factors. In addition, personal communication with policymakers, NHSO administrators and staff, and other key stakeholders was carried out for the purpose of data verification.

The data and information were analysed by all of the researchers in face-to-face meetings. A content analysis approach was employed. The text in the relevant documents was read, scrutinised and interpreted according to the specific themes illustrated in the conceptual framework. In the cases where the researchers had different interpretations, thorough discussion was undertaken until common understandings and agreements were achieved.

The conceptual framework of this study is drawn from Clark and Weale's (2011) categorisation of the social values that influence health prioritisation in which the process of decision making and the values that were applied are considered separately. Process values refer to the features of the decision-making processes. These include transparency, accountability and participation. Meanwhile, content values are the ideals pursued whilst decision makers appraise particular interventions. For instance, a high priority may be given to the technologies which offer value for money and/or enhance equity and solidarity.

Despite potential conflicts with each other, the social values in the two categories may drive the reform of the UC benefit package development on two levels. First, they dictate the process guidelines that govern the benefit package formulation, given the NHSO's desire to ensure good governance. However, to understand whether and how these ideals were translated into practice, an examination similar to the one carried out in this analysis is needed. The second level of policymaking for which social value judgments can have influences is related to the appraisals of individual technologies. In most settings, the processes through which public health benefit coverage is determined comprise five major steps: nomination of interventions, prioritisation of candidate interventions, and assessment of priority interventions, appraisal, and appeal. Since the policymakers and stakeholders involved in policy development possess a variety of interests and ideals (Walt, 1994), the decisions made in each step, including those on the adoption or rejection of an intervention, are guided by different values.

The case study approach is widely utilised for analysing public policies as it is helpful in providing explanations on how and why particular policies were developed (Yin, 1994). Despite relatively limited generalisability, the findings of a case study offer in-depth understandings for complex social phenomena such as the competing ideals of actors who participate in certain policy processes (Keen and Packwood, 1999). In this study, three interventions were purposively selected from those proposed to the UC package in 2010:

- (1) absorbent materials for the elderly and disabled with incontinence;
- (2) drug treatment for HBeAg positive chronic hepatitis B (CHB) patients; and
- (3) allogeneic hematopoietic stem cell transplantation (HSCT) in severe thalassemia.

In the selection of case studies, key features such as prices and populations in need of each candidate intervention were considered; priority was given to those likely to carry diverse content values in the coverage decisions. As suggested in preliminary document reviews, the provision of absorbent materials for the elderly and disabled obtained strong support from stakeholders, even though the enormous budget implications were foreseeable. Meanwhile, policymakers were reluctant to offer access to hepatitis B therapy, in spite of its affordable costs and value for money. Finally, stem cell transplantation in thalassemia cases was adopted with some conditions, since existing evidence demonstrated that it was cost-effective, but that the financial burdens would be high.

### Results

To address the demands for systematic and transparent approaches in policymaking, an initiative to devise new mechanisms for the formulation of the UC benefit package was instigated in October 2009 as a collaborative project carried out by two research arms of the Ministry of Public Health, namely the Health Intervention and Technology Assessment Program (HITAP) and the International Health Policy Program (IHPP) (HITAP-IHPP, 2011). Based on the experiences of seven health technology assessment (HTA) agencies in Europe and North America, process guidelines for the UC coverage decisions (National Health Security Office, 2010) were developed through extensive consultations among policymakers, health professionals, academics, patient groups, industry actors, civil society organisations, and groups of lay people. Table I illustrates

Steps	Stakeholders involvement	Guidelines/criteria
Nomination of health interventions for assessment	Topics are nominated by policymakers, health professionals, academics, patient groups, industry actors, civil society organisations, and lay people	The process guidelines (National Health Security Office, 2010)
Prioritisation of proposed topics	A panel consisting of health professionals, academics, patient groups, and civil society organisations prioritises the topics	The process guidelines and topic selection criteria (National Health Security Office, 2010)
Technology assessment	HITAP and IHPP researchers act as principal investigators with support from relevant experts	The national methodological guidelines for technology assessment (HITAP, 2009)
Appraisal	The SCBP is solely responsible for final decisions. In some circumstances, mainly in coverage of medicines, it may transfer the case to the NLEM subcommittee	None

**Table I.**  
Stakeholder participation in each step of the UC coverage decisions and related guidelines/criteria

**Notes:** SCBP stands for the Subcommittee for Development of Benefit Package and Service Delivery; NLEM for the National List of Essential Medicines

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the major steps, stakeholder involvement, and related guidelines/criteria developed as critical components of the reform initiative.

#### *Nomination of health interventions for assessment*

According to the newly developed guidelines (National Health Security Office, 2010), representatives of policymakers, health professionals, academics, patient groups, industry, civil society, and lay people are allowed to propose interventions for consideration. These proposals should be submitted together with basic information indicating how they were obtained, e.g. through consultations or surveys within the organisations, and what the rationale of the proposal is. It should be noted that stakeholders may also suggest that the SCBP consider diseases or health problems which are not well addressed in the UC.

#### *Prioritisation of proposed interventions*

In this step, representatives of four groups of stakeholders – health professionals, academics, patient groups, and civil society organisations – are appointed to sit on a panel overseeing intervention prioritisation. To undertake the task, the panel introduces six agreed criteria: size of afflicted population, severity of problems, effectiveness of interventions, variation in practice, economic impact on household expenditure, and ethical and social implications. A scoring approach with well-defined parameters and thresholds was employed to address each criterion. However, the ranks of interventions could be adjusted through deliberation among the panellists, and those which were prioritised would be recommended to the SCBP for endorsement.

#### *Technology assessment*

HITAP and IHPP researchers are responsible for assessing the cost-effectiveness and budget implications of each priority intervention. They quantify the marginal cost and health outcomes as quality-adjusted life years (QALY) arising from the introduction of a new intervention compared to the standard practice. The results of this evaluation are presented in the form of an incremental cost-effectiveness ratio (ICER). In so doing, both institutes follow the national methodological guidelines for HTA (HITAP, 2009), and also collaborate with external experts and relevant stakeholders in certain phases of the research to fine-tune the research questions and their scope, conduct assessments, validate results, and prepare policy recommendations.

#### *Appraisal*

The SCBP, comprising multi-disciplinary members including policymakers, health professionals, civil society networks, and patients groups, is tasked with making UC coverage decisions. Despite the reform, written guidelines for technology appraisal are still lacking. In practice, the SCBP requests evidence on the economic and financial consequences of priority interventions from the two research units. However, the extent to which such information affects coverage decisions varies across the candidate interventions.

It is noteworthy that a mechanism of appeal against the SCBP's decisions was not included in the first version of the process guidelines.

## How social values shape health resource allocation in Thailand – three case studies

### *Absorbent products for the disabled*

In 2010, civic groups proposed that absorbent products such as diapers for adults be adopted as a UC benefit due to the hardships endured by the disabled and elderly suffering from incontinence (HITAP-IHPP, 2011). Currently, no public health plan subsidises these products, and over 360,000 people would benefit from their allocation. According to a preliminary assessment, the absorbent materials could reduce the risk of complications from catheterisation, relieve the financial burden of US\$1,200 per capita annually (1 Baht = US\$0.0334), and also improve quality of life. As agreed in a consultation with stakeholders, HITAP in collaboration with practitioners at two rehabilitation hospitals conducted a quality of life study followed by an evaluation of the cost-utility and budget implications of reimbursing diapers for the most vulnerable group under consideration – the disabled. These assessments suggest a statistically significant increase of 32 per cent in quality of life scores after free diapers were provided for 10 weeks, resulting in an ICER of US\$1,804/QALY and a budget impact of US\$650 million/year. Although the allocation of diapers incurred substantial expenditure without prolonging life, the researchers recommended that the SCBP subsidise this intervention because of the improvements in quality of life for one of the most vulnerable groups in society (Tonmukayakul *et al.*, 2011). Initially, the SCBP concurred with the recommendations based on solidarity and the availability of local production. However, coverage for such products was finally denied, owing to the large budget impact.

### *Drug treatment in HBeAg positive chronic hepatitis B (CHB) patients*

In 2010, health professionals proposed the inclusion of additional pharmaceutical treatments for CHB (HITAP-IHPP, 2011). At that time, six medications (*lamivudine, adefovir, entecavir, telbivudine, interferon, pegylated interferon*) were licensed for this indication. In addition, *tenofovir* was approved for HIV treatment, but was being used for CHB in Thailand and elsewhere. Only *lamivudine* was included in the NLEM and, therefore, *lamivudine*-resistant CHB patients, especially those under the UC scheme, did not have access to alternative medications. Subsequently, a scoping consultation with stakeholders resulted in an agreement to estimate the cost-utility of 29 treatment options and their budget impact (Tantai, 2011). The assessment suggested that providing generic *lamivudine* and then *tenofovir* when drug resistance occurred and providing *tenofovir* monotherapy were two cost-saving options. The former regimen was the most optimal and could save US\$2,300 per patient as a result of averting cirrhosis or liver cancer cases. In addition, the treatment could prolong overall survival for 18 years. The findings were presented to the SCBP and also referred to the NLEM subcommittee. Although both subcommittees noted that the treatments were cost-saving, the decision was put on hold due to the substantial budget impact and the infeasibility of offering the treatments to all patients in need (HITAP-IHPP, 2011). The latter reason was crucial because the current “bottleneck” was created by the practice of liver biopsy before prescribing these drugs. Since only a limited number of sub-specialists can perform these procedures, it was argued that coverage would increase the benefits of only a small number of patients who already have access to

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these drugs, which therefore undermines equity. The final decision will be made only after seeking information on the possibility of prescribing these drugs without biopsy.

#### *Allogeneic hematopoietic stem cell transplantation (HSCT) for severe thalassemia*

Because organ transplantation is considered unaffordable, it has been excluded from the UC benefit package since the scheme was established in 2001 (Ministry of Public Health, 2001). Demands from health professionals, politicians, and the public for the reimbursement of costs incurred from certain organ transplantations led the NHSO to request that HITAP conduct an economic evaluation on HSCT for severe *thalassemia*. The selection of this topic was also supported by the fact that HSCT for leukaemia has been provided in a pilot project under the UC since 2006 (National Health Security Office, 2006). A team of researchers found that, compared to supportive care, the ICER increased with patient age from US\$2,600 to 6,000/QALY gained for related HSCT and from US\$6,900 to 31,000/QALY gained for unrelated HSCT among patients aged 1-15 years old (Leelahavarong *et al.*, 2010). The budget impact estimated for the number of possible transplantations performed each year, based on approximately 200 cases of patients aged 1-10 years old in accordance with the current cost-effectiveness threshold, would initially require approximately US\$3 million additionally per year. The SCBP favoured the recommendations because they were in line with equity and disease severity principles, and requested a feasibility study on increasing the capacity for HSCT in severe *thalassemia* (HITAP-IHPP, 2011).

#### **Discussion**

This analysis illustrates the efforts taken to ensure systematic and transparent operations as part of good governance in coverage decisions in the Thai context. This reflects the social accountability of the SCBP as the authority initiated its own internal reform. In reviewing international experiences, HITAP and IHPP identified other process values which have been introduced into healthcare prioritisation in other settings. These values include participation and contestability (HITAP-IHPP, 2011). However, only the former ideal was accepted by the SCBP and incorporated into the process guidelines for benefit package development. It is unsurprising that the contestability was not welcome by the authority as policymakers tend to avoid challenges over their decisions. Recently, however, the panel on HTA topic selection put pressure on the SCBP to show justifications for their appraisal results, and also to allow access to related evidence. Reluctantly accepted by the Subcommittee, this proposal will provide the opportunity for stakeholders to verify whether coverage decisions are based on accurate information (National Health Security Office, 2011). The SCBP also agreed that if such information was unreliable or inaccurate, the stakeholder panel could launch an appeal.

Process values identified in this study, including transparency, participation and accessibility of information, are interconnected. This is in line with existing assertions that all elements of good governance should be mutually supportive and reinforcing (Asian Development Bank, 1999). We found that stakeholder involvement in the UC coverage decisions led to a gradually increased sense of policy ownership and demand for contestability amongst these participants. Presumably, this was because they wanted to strengthen the decision-making processes. Although most stakeholders participate in policies to pursue their own interests or benefits for their networks (Walt,

1994), it could be maintained that through transparent deliberations, they must have good reasons to support their arguments against others.

In the reform, the criteria for prioritising candidate interventions consisted of five elements which mirror certain content values. Apart from the magnitude of proposed health problems and effectiveness of solutions, equity and moral considerations are noticeable, as reflected by three parameters: variation of practice, financial burdens on households, and social/ethical implications of problems (HITAP-IHPP, 2011). The latter, as a composite parameter, gives priority to problems with low incidences and those mostly afflicting the disadvantaged. Furthermore, deliberations among stakeholders provide opportunities to insert other values such as welfarism, ethics and equity into the prioritisation.

Based on our observations, the entire processes of the topic priority setting, assessment, and appraisal of the adult diaper case were apparently guided by sympathy for the disabled with incontinence. In the presentations and discussions of stakeholders, members of the SCBP and HITAP researchers, emotional statements and touching pictures were introduced. Although the proposal was finally denied by the Subcommittee, it seemed that all parties strongly supported free access to this intervention among the needy population. The analysis of CHB treatment policy indicates an effort of this Subcommittee to ensure equity in health by removing the barriers to medicines under consideration. For the case of HSCT, it was partly because of inequitable access to the treatments among *thalassemic* patients under different health plans, as well as among UC patients with *thalassemia* and leukaemia who needed the same treatments that led to the adoption of this technology.

Although the reform of the UC benefit package development aims for systematic and transparent processes, these goals have not yet been accomplished. A crucial reason for this is the lack of technology appraisal guidelines. Despite established processes and criteria for the nomination, prioritisation and assessment of candidate interventions, experiences in 2009 and 2010 suggest that the SCBP made final decisions on an inconsistent and, in some instances, implicit basis. Although the authority requests cost-effectiveness information from responsible research units, and these three case studies represented good value for money, the roles of other values were considered more crucial. The case of incontinence diapers demonstrates the importance of the budget impacts which made the SCBP deny the request for the provision of free access to this costly intervention. However, there has been no direction and threshold for the financial consequences of including a new intervention in the UC package. The lack of clarity to make decisions on the budget impacts of health interventions can be found in many countries including those with high incomes. It has been argued that budget impact is not perceived as a rational decision criterion, and is, therefore, rarely used as justification for denying intervention coverage (Niezen *et al.*, 2009). In contrast, Thai policymakers are not reluctant to spell out that the financial burden and affordability are among their major concerns when they consider new investments (Youngkong *et al.*, 2010). This might be because the constraints of financial resources in the Thai health care system have been widely recognised, and it is not difficult for stakeholders to understand whether a technology is costly or not. All these elements result in non-significant public pressure on the government.

The issues of equity and ethics are usually raised to justify health resource allocation in Thailand and elsewhere. Nevertheless, the roles of these content values in

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policy decisions are debatable. Policymakers and stakeholders could apply these ideals to support the adoption of cost-ineffective technologies and/or those with substantial budget requirements. Previous literature suggests that analysing ethics as part of HTA is problematic in many aspects, such as stakeholders' attitudes, responsible authorities, conceptual frameworks, methods and practical guidelines (Duthie and Bond, 2011). As some scholars point out, an ethical assessment of technologies refers to a systematic inclusion of the public perspective in decision-making (Velasco *et al.*, 2002), while others emphasise the need for analysis undertaken by bioethicists or social scientists in respective disciplines (Lehoux and William-Jones, 2007). In the development of the UC process guidelines, there was little discussion on how to address the value of ethics in prioritising the proposed topics, and such a concern was addressed by providing a priority to health problems mainly afflicting marginalised people. In the introduction phase, ethics arguments among policymakers and stakeholders could be observed in every stage of the benefit package development; however, the deliberations were not assessed systematically, and the influence of these arguments on policymaking relied on subjective analysis.

In a similar vein, the assessment of equity or social fairness in the UC coverage decisions is contentious. Introduced during the prioritisation of proposed candidate interventions, the equity-related criterion involves variation of the practice of the three publicly-financed benefit schemes, which results in uneven coverage for particular interventions. According to the process guidelines, priority is given to the services uncovered by the UC, but is available for the CSMBS and/or SSS beneficiaries. In the appraisal phase, however, the cases of CHB treatment and HSCT in *thalassemia* illustrate that standardisation of equity assessment methods as well as the systematic integration of this value into the final decisions are required. It should be noted that both the SCBP and NLEM Subcommittee have applied equity principles to deny some candidate interventions because existing benefits with similar indications had not been adequately accessed by particular needy populations. As a result, the Subcommittees recommended improvements to the existing programme coverage rather than appraising new candidates.

The reform of Thailand's UC package formulation also indicates the need for revisiting the conceptual framework of this study, which may in turn contribute to a better understanding of how social values shape health priority settings in different societies. First, as already discussed, there are inter-linkages between process values, which make their roles in policymaking dynamic. In this respect, the analysis should be conducted over an appropriate length of time in order to garner insights into the shifts in policies and their underlying values. Second, investments in particular health services are not solely guided by values, but also by the features of policy participants, as individuals and networks, as well as by contextual factors (Walt and Gilson, 1994). The framework should, therefore, be expanded to capture the influences of competing interests and unevenly distributed power among stakeholders, and determine how these elements connect to the prevailing social values in each decision. In the development of the UC process guidelines and in the three case studies, we can see that the SCBP took a leading role in almost every step, even though the involvement of other parties was allowed. Moreover, some stakeholders with less power, such as patient groups and civil society organisations, might be unintentionally discriminated against. Since lay people alliances were less capable than their academic and

professional counterparts of participating in technically-oriented processes, the former's values and related preferences were less likely to be well recognised and accepted.

Besides, provided that the politico-economic context – especially the country's political culture, economic status, available resources, and collective capability of government institutes – has a critical role in policy development and implementation (Hanson *et al.*, 2003), such environmental elements cannot be ignored in the analysis of resource allocation as these factors may either suppress or enhance the roles of process and content values in several ways. For instance, it is difficult to pursue the social accountability, participation, and transparency of policy decisions in authoritarian states (Hill and Hupe, 2002). Another illustration can be drawn from the rejection of diapers for incontinent patients, whereby the high costs concomitantly with financial constraints made universal coverage for this intervention unaffordable. From a different angle, this phenomenon can also be regarded as competition between the content values of cost-effectiveness, affordability, feasibility, equity and ethics, which makes coverage decisions more complex than demonstrated in the current conceptual framework.

### Conclusions

The Thai experience represents an effort to make coverage decisions in the country's largest health plan more transparent, participatory, systematic and evidence-based. Although explicit guidelines underpinned by efficiency and other ideals existed, in some instances, disparities between the guidelines and practice could be observed, as the benefit package formulation was driven by different value judgments. To get insights into the role of social values in policy development, which will contribute to further improvement of the decision making processes as well as stakeholder participation, there is a need for a comprehensive framework which captures actor involvement, the influences of contextual factors, and the processes through which all of such elements interact with each other.

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